

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Kutnam
 Civil Dist. 8
 OR
 Village _____
 OR
 City _____ (No. _____ St.; _____ Ward)

STATE OF TENNESSEE

STATE BOARD OF HEALTH
 Bureau of Vital Statistics

CERTIFICATE OF DEATH

Registration District No. 47208
 Primary Registration District No. _____

8816

File No. 58

Registered No. _____

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Bob. Raekler

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED W
 (Write the word)

6 DATE OF BIRTH about 1 1887
 (Month) (Day) (Year)

7 AGE 42 yrs. mos. ds. If LESS than 1 day, _____ hrs. or _____ min.?

8 OCCUPATION farmer 000
 (a) Trade, profession, or particular kind of work.
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Kutnam Co.

10 NAME OF FATHER John Raekler

11 BIRTHPLACE OF FATHER (State or country) DeKalb Co.

12 MAIDEN NAME OF MOTHER Lizza Harris

13 BIRTHPLACE OF MOTHER (State or country) DeKalb Co.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

[Informant] W. J. Harris

[Address] Liberty Point etc

15

Filed 3/16 1929 J. V. Herron
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 3 9 1929
 [Month] [Day] [Year]

17 I HEREBY CERTIFY, That I attended deceased from _____ 192, to _____ 192,

that I last saw h. _____ alive on _____, 192

and that death occurred, on the date stated above, at _____ M

The CAUSE OF DEATH* was as follows: pneumonia fever 2056

[Duration] _____ yrs. _____ mos. _____ ds.

Contributory [SECONDARY] _____

[Duration] _____ yrs. _____ mos. _____ ds.

Signed no Dr. _____ M. D.

_____ 192 Address _____

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. State whether or not an operation was performed.

18 LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS TRANSIENTS, OR RECENT RESIDENTS]

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Pleasant View DATE OF BURIAL 3/8 1929

20 UNDERTAKER J. V. Herron ADDRESS _____